wisconsin Medicaid update
department of health and family services
July 1999 • No. 99-40
POH 1680

To:
County Departments of Community Programing
County Human Service Departments
County Social Service Departments
County Mental Health Coordinators
County/Tribal Aging Units
County Substance Abuse Coordinators
County-owned Mental Health/ Substance Abuse Clinics
Tribal Human Service Facilitators
HMOs & Managed Care Programs

Mental health and substance abuse outpatient services in the home or community

Wisconsin Medicaid now covers mental health and substance abuse (alcohol and other drug abuse) outpatient services provided in a home or community setting when counties or tribes pay the non-federal share.

Provisions of 1997 Wisconsin Act 27, the state biennial budget, authorized Wisconsin Medicaid to expand the settings in which mental health and substance abuse (alcohol and other drug abuse) outpatient services may be provided. This expansion allows provision of services in *the home or community* for adult recipients.

Wisconsin Medicaid pays only county or tribal agencies for these services, and only the federal share of the allowable Medicaid reimbursement. In turn, the county or tribal agencies pay the nonfederal share [ss. 49.45(45) and 49.46(2)(b)6fm, Wis. Stats.].

Medicaid HMOs continue to have the flexibility of providing mental health and substance abuse outpatient services in the home or community. Medicaid HMO enrollees *may* receive these services in these settings under fee-for-service, *provided* they receive county or tribal authorization.

Authorization for fee-for-service outpatient services in the home or community must be obtained from the county or tribal agency. The county or tribal agency determines the therapeutic need for the home or community setting. If the county or tribal agency determines the setting is not therapeutically necessary for the individual recipient, the HMO must provide the services needed by the enrollee.

To ensure continuity of care, HMOs may wish to collaborate with counties in developing innovative approaches to the provision of mental health and substance abuse outpatient services in the home or community.

This Update includes the following information:

- What is required to be **eligible** for Medicaid reimbursement.
- Which services are **covered** in the new settings.
- How services are **reimbursed**.
- How to **bill** for services performed in the new settings.

A certification addendum and the following attachments are included in this Update:

Attachment	Subject
1	Documentation Requirements
2	Procedure Codes & Fee Schedule
3	HCFA 1500 Claim Form Completion Instructions
4 and 5	Examples of Completed HCFA 1500 Claims

Reimbursement requirements

The county or tribal agency must meet the following three requirements in order to be eligible to receive Medicaid reimbursement:

1. Medicaid certification.
2. Board/agency resolution.
3. Addendum to Medicaid certification.

Requirement 1: Medicaid certification

If your county or tribal agency *is* certified as a Medicaid mental health/substance abuse clinic, you do not need to complete a new provider application.

If your county or tribal agency *is not* certified as a mental health/substance abuse clinic, and you would like to provide and bill for services in the new settings, you are required to:

- Be certified as a mental health/substance abuse clinic under HFS 61.91 to 61.98 or HFS 61.50 to 61.68, Wis. Admin. Code, by the Division of Supportive Living (DSL). Request this application from the Program Certification Unit, DSL, at (608) 266-0120.
- Be certified as a Medicaid provider. After receiving DSL certification, call Provider Services at (800) 947-9627 or (608) 221-9883 to request a Medicaid certification application.

If your county or tribal agency *is not* currently certified as a mental health/substance abuse clinic, and you would like to only bill for services in the new settings, you are required to:

- Submit an abbreviated "Medicaid billing only" provider application. Call Provider Services at (800) 947-9627 or (608) 221-9883 to request a Medicaid "billing only" application.
- Contract *only* with Medicaid-certified mental health or substance abuse clinics, psychiatrists, and Ph.D. psychologists.

Requirement 2: Board/agency resolution

Wisconsin *Medicaid Update* 98-14, dated May 19, 1998, notified counties and tribal agencies wishing to provide these services of the requirement to obtain a resolution from its board. The resolution must state that the county or tribe agrees to make available the non-federal share needed to provide Medicaid mental health and substance abuse outpatient services in a home or community setting. Agency resolutions, such as 51.42 or human services board resolutions, meet this requirement. Reimbursement will not be made for any service provided more than 365 days prior to the date of the resolution even though claim submission was within 365 days of the date of service.

Requirement 3: Addendum to Medicaid certification

The addendum is a one-page form indicating whether the county or tribe intends to be only a "biller" of these services or intends to perform and bill for these services. The addendum also serves as verification that the agency understands the requirements and has received a resolution from its board to provide the non-federal share for services in home or community settings. The addendum is included in this Update.

Where to submit the addendum and board/agency resolution

Submit a copy of the addendum and board/agency resolution to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Covered services in home or community settings

Mental health and substance abuse services provided in home or community settings are the same Medicaid-reimbursable mental health and substance abuse outpatient services as de-

scribed in HFS 107.13 (2) and (3), Wis. Admin. Code, but the services are provided in the home or community. These services include evaluations, psychotherapy, and substance abuse therapy. Services must be provided by Medicaid-certified mental health/substance abuse clinics, psychiatrists, or Ph.D. psychologists.

Wisconsin Medicaid defines "home or community" as those settings that are therapeutically necessary for the recipient (e.g., a person's home, senior citizen center). Therapeutic reasons must be documented to show that the setting is necessary, as required in HFS 61.97 (8), Wis. Admin. Code.

Wisconsin Medicaid covers services performed in the following settings under the regular Medicaid substance abuse and mental health outpatient benefit:

- Hospital.
- Hospital outpatient clinic.
- Nursing home.
- Outpatient facility.
- Provider's office.
- School.

Documentation of services provided

Wisconsin Medicaid requires documentation under HFS 106.02 (9), Wis. Admin. Code. Refer to Attachment 1 of this Update for the documentation requirements.

Reimbursement information

Wisconsin Medicaid will reimburse only counties or tribes, and only the federal share of the Medicaid reimbursement rate for these services. Counties or tribes must provide the non-federal share as specified in s. 49.45 (45) (b), Wis. Stats.

Effective October 1, 1998, the federal share is 58.84 percent; the non-federal share is 41.1 percent. Effective October 1, 1999, the federal share will be 58.78 percent; the non-federal share will be 41.24 percent. The federal share may change in October of each year. You will be notified of those changes in future Wisconsin Medicaid Updates.

Medicaid will send a quarterly report to each county or tribe indicating the federal share amount that the agency has received thus far in a calendar year. The agency may use this report when calculating the non-federal share for which it is responsible.

If a county or tribe contracts with other Medicaid-certified providers for these services, the county or tribe pays those providers according to the terms of their contracts with them.

Non-federal share requirements

The requirements for the non-federal share are the same used for certain other Medicaid services such as community support programs, case management, and crisis intervention. Wisconsin Medicaid requires counties or tribes to maintain written documentation that the non-federal share funds meet all of the following conditions:

1. The funds used must be public funds (e.g., community aids, county tax levy).
2. The funds used may not be federal dollars, unless the federal dollars are authorized by federal law for use as matching funds for other federal dollars.
3. The funds used may not be state or local dollars that are used to match other federal dollars.

Reimbursement rates

Refer to Attachment 2 for the list of Medicaid reimbursement rates for mental health and substance abuse outpatient services in home or community settings.

Billing information

Usual and customary billing

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for the service provided.

Using the procedure codes from Attachment 2, providers may submit claims electronically or on the HCFA 1500. Mail completed claims for payment to Claim Submission, 6406 Bridge Road, Madison, WI 53784-0002. Refer to Attachments 3-5 for specific billing instructions and claim examples.

Reminder about community service deficit reduction

All counties or tribes claiming Medicaid reimbursement for mental health or substance abuse outpatient services in the home or community may file a cost report for these services under the community service deficit reduction. Counties and tribes are able to claim the federal matching dollars to cover approximately 60% of their deficits above the Medicaid reimbursement rate for certain Medicaid-covered services. The agency's operating deficit for a particular program is the difference between the approximate 60% of the public agency's cost to provide the service and the agency's Medicaid reimbursement for the service.

Medicaid Update 96-28, dated July 31, 1996, explains community service deficit reduction in greater detail.

If you have questions

If you have questions about the Medicaid certification or billing information in this Update, or would like to obtain copies of *Medicaid Updates* 96-28 or 98-14, contact Provider Services at (800) 947-9627 or (608) 221-9883.

Copies of *Medicaid Updates* 96-28 and 98-14 are also available on the Internet:

www.dhfs.state.wi.us/Medicaid/provider/provpubs/updates/pubupdat.htm

If you have additional policy questions about the information in this Update, contact:

Christine S. Wolf, CICSW
Mental Health/Substance Abuse Policy Analyst
Division of Health Care Financing
Room 350
P. O. Box 309
Madison, WI 53701-0309
(608) 266-9195

If you have questions about DSL certification, contact:

Program Certification Unit
Bureau of Quality Assurance
Division of Supportive Living
P. O. Box 7851
Madison, WI 53701-7851
(608) 266-0120

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For more information, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our web site at *www.dhfs.state.wi.us/medicaid.*

Wisconsin Medicaid
Certification Addendum

Adult Mental Health and Substance Abuse Services in the Home or Community

Agency Name

Address

Phone

Our county or tribal agency plans to participate in providing Medicaid-covered mental health and substance abuse services in home or community settings. I understand that our agency must provide the non-federal share payments for these services. Attached is the county or tribal resolution that permits our agency to participate and provide the non-federal share for all Medicaid federal share payments. Reimbursement will not be made for any service provided more than 365 days prior to the date of the resolution even though claim submission was within 365 days of the date of service. I understand that our agency must abide by all Medicaid requirements, including specific requirements for substance abuse/mental health services in the home and community.

Please check one of the following

☐ Our agency is currently Medicaid certified to provide mental health or substance abuse outpatient services. We understand that we may render or contract with other Medicaid-certified outpatient mental health/substance abuse provider(s) for provision of these services. Our Medicaid provider number is:_____.

☐ Our agency is not currently Medicaid certified to provide mental health or substance abuse outpatient services. We would like to render and bill for these services. Attached is the certification packet for mental health/substance abuse outpatient services.

☐ Our agency is not currently Medicaid certified to perform outpatient mental health or substance abuse outpatient clinic services and we would like to only bill for these. We do not wish to render these services. We understand we are required to contract only with Medicaid-certified mental health or substance abuse clinics, psychiatrists, and Ph.D. psychologists to actually perform these services. Attached is a completed "billing only" certification packet for these services.

_____ _____

Authorized Agency Representative Date

☐ Yes, the resolution is attached.

Attachment 1

Covered Outpatient Mental Health and Substance Abuse Services in Home or Community Settings

Documentation Requirements

The following is Wisconsin Medicaid's medical record documentation requirements [HFS 106.02 (9)., Wis. Admin. Code] as it applies to mental health and substance abuse outpatient services. In each element, the applicable administrative code language is in parentheses.

The provider is required to include in the recipient's medical record the following written documentation, as applicable.

1. Date, department or office of the provider, as applicable, and provider name and profession.
2. Presenting Problem (chief medical complaint or purpose of the service or services).
3. Initial assessment (clinical findings, studies ordered, diagnosis or medical impression).
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood/affect, thought processes – principally orientation X3, dangerousness to others/self, and behavioral observations/motor. Other information which may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings).
   d. Biopsychosocial history, which may include, depending on the situation, educational/vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal/legal history, significant past relationships/prominent influences, behavioral history, financial history, and overall life adjustment (studies ordered).
   e. Current status, including mental status, current living arrangements/social relationships, support system, current activities of daily living, current/recent substance abuse usage, current personal strengths, current vocation/educational status, and current religious attendance (clinical findings).
4. Initial treatment plan, including treatment goals, planned intervention, mechanics of intervention [frequency, duration, responsible party(ies)] (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided.)
5. Progress notes (therapies or other treatments administered).

Attachment 2

Mental Health and Substance Abuse Services in the Home or Community

Procedure Codes and Fee Schedule

Not all providers may be reimbursed for all mental health or substance abuse (alcohol and other drug abuse) outpatient services. To determine which certified providers may be reimbursed for a particular service, please consult the following chart.

Procedure Code	Type of Service	Description	Who May Perform Service	Unit Rate†	Reimbursement (Federal Share)	Allowable Diagnoses	Allowable Place of Service ‡
W7400	1	Psychiatric Diagnostic Interview Exam - Home or Community by Psychiatrist	Psychiatrist	$129.62	$76.28	All	0, 4
W7401	9	Psychiatric Diagnostic Interview Exam - Home or Community by Ph.D.	Ph.D. Psychologist	$97.22	$57.21	All	0, 4
W7402	9	Psychiatric Diagnostic Interview Exam - Home or Community by Master's	Psychotherapist	$77.78	$45.77	All	0, 4
W7403	1	Individual Psychotherapy/ Substance Abuse Therapy - Home or Community by Psychiatrist	Psychiatrist	$129.62	$76.28	290 - 316	0, 4
W7404	9	Individual Psychotherapy/ Substance Abuse Therapy - Home or Community by Ph.D.	Ph.D. Psychologist	$97.22	$57.21	290 - 316	0, 4
W7405	9	Individual Psychotherapy/ Substance Abuse Therapy - Home or Community by Master's	Psychotherapist	$77.78	$45.77	290 - 316	0, 4
W7406	1	Individual Substance Abuse Therapy - Home or Community by AODA Counselor	AODA Counselor	$51.83	$30.50	290 - 316	0, 4

† Hourly except for codes W7413 and W7414.

‡ Place of service (POS) codes: 0 equals other, 4 equals home.

Procedure Code	Type of Service	Description	Who May Perform Service	Unit Rate†	Reimbursement (Federal Share)	Allowable Diagnoses	Allowable Place of Service ‡
W7407	1	Individual Substance Abuse Therapy - Home or Community by M.D. other than Psychiatrist	Physician other than Psychiatrist	$129.62	$76.28	290 - 316	0, 4
W7408	1	Group Psychotherapy/ Substance Abuse Therapy - Home or Community by Psychiatrist	Psychiatrist	$32.41	$19.07	290 - 316	0, 4
W7409	9	Group Psychotherapy/ Substance Abuse Therapy - Home or Community by Ph.D.	Ph.D. Psychologist	$24.29	$14.29	290 - 316	0, 4
W7410	9	Group Psychotherapy/ Substance Abuse Therapy - Home or Community by Master's	Psychotherapist	$19.44	$11.44	290 - 316	0, 4
W7411	1	Group Substance Abuse Therapy - Home or Community by AODA Counselor	AODA Counselor	$12.97	$7.63	290 - 316	0, 4
W7412	1	Group Substance Abuse Therapy - Home or Community by M.D. other than Psychiatrist	Physician other than Psychiatrist	$32.41	$19.07	290 - 316	0, 4
W7413	1	Pharmacologic Management - Home or Community by M.D./N.P./P.A. (Quantity 1=15 minutes)	Physician Nurse Practitioner Physician's Assistant	$32.41	$19.07	290 - 316	0, 4
W7414	9	Pharmacologic Management - Home or Community by Psychiatric Nurse (Quantity 1=15 minutes)	Master's-Level Psychiatric Nurse	$19.45	$11.45	290 - 316	0, 4

† Hourly except for codes W7413 and W7414.

‡ Place of service (POS) codes: 0 equals other, 4 equals home.

Attachment 3

Mental Health and Substance Abuse Outpatient Services in Home or Community

HCFA 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. All elements listed below must be completed with the required data; no other elements are required.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 - Program Block/Claim Sort Indicator

For county-owned clinics that are not "biller only" providers, enter claim sort indicator "M" in the Medicaid check box for the service billed. For tribal clinics and "biller only" providers, enter claim sort indicator "P" in the Medicaid checkbox for the service billed.

Element 1a - Insured's I.D. Number

Enter the recipient's 10-digit Medicaid ID number. Do not enter any other numbers or letters.

Element 2 - Patient's Name

Enter the recipient's last name, first name, and middle initial. Write the name exactly as it appears on the Medicaid ID card.

Element 3 - Patient's Birth Date, Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., December 18, 1970, would be 12/18/70) or in MM/DD/CCYY format (e.g., December 18, 1970, would be 12/18/1970). Specify if male or female with an "X."

Element 5 - Patient's Address

Enter the complete address of the recipient's place of residence.

Element 9 - Other Insured's Name

Third-party insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave element 9 blank.
- When the recipient has an HMO as a private insurance plan, one of the HMO insurance codes from table 3.1 must be indicated, ***if applicable.*** ***Important Note***: The provider may not use OI-H if the HMO denied payment because an otherwise

Table 3.1 *HMO Disclaimer Codes used in element 9, "Other Insured's Name."*

HMO Disclaimer Codes	
Code	*Description*
OI-P	**Other Insurance Paid** Claim is paid entirely or in part by a (non-Medicaid) HMO. Indicate on claim the amount paid by the HMO to the provider or the insured.
OI-H	**Other Insurance HMO** Claim is not covered by an HMO or the billed amount does not exceed the coinsurance or deductible amount. Do not use OI-H if an otherwise covered service was not rendered by a designated provider.

covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, then one of the three other insurance (OI) explanation codes from Table 3.2 ***must*** be indicated in the ***first*** box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Table 3.2 *Insurance Disclaimer Codes used in element 9, "Other Insured's Name."*

HMO Disclaimer Codes	
Code	*Description*
OI-P	**Other Insurance Paid** Claim is paid entirely or in part by other insurance. Indicate on claim the amount paid by other insurance to the provider or the insured.
OI-D	**Other Insurance Denied** Claim is denied by other insurance following submission of a correct and complete claim or application of payment toward the coinsurance and deductible. Do not use this code unless the claim in question was billed to and denied by the other health insurance.
OI-Y	**Other Insurance Yes** Other insurance coverage was indicated but it was not billed for reasons including, but not limited to: • Recipient denies coverage or will not cooperate. • The provider knows the carrier does not cover the service in question. • Insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get an assignment.

Element 17 - Name of Referring Physician or Other Source

Enter the referring or prescribing provider's name. For evaluations, leave blank.

Element 17a - I.D. Number of Referring Physician

Enter the referring or prescribing provider's six-character UPIN number. If the UPIN number is not available, enter the eight-digit Medicaid provider number or license number of the referring or prescribing provider.

Element 21 -Diagnosis or Nature of Illness or Injury

Enter *The International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St. Anthony Publishing, Inc.
P. O. Box 96561
Washington, D.C. 20090
(800) 632-0123

Element 24A - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/CCYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY or MM/DD/CCYY format in the "From" field, and subsequent dates of service in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B - Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. Use POS "0" for "Other" and POS "4" for "Home."

Element 24C - Type of Service Code

Enter the appropriate Medicaid single-digit type of service (TOS) code for each service.

Psychiatrists, physicians, physician assistants, nurse practitioners: Use type of service (TOS) "1."

Ph.D. Psychologist, Master's-level therapists: Use type of service (TOS) "9."

Master's-level therapists are master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. (This includes registered nurses with a master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)

AODA counselors: For AODA counselors who are not one of the above, use type of service (TOS) "1."

Element 24D - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code. Refer to Attachment 2 of this Update for the list of allowable procedure codes for home and community services.

Element 24E - Diagnosis Code

When multiple procedures related to different diagnoses are listed, enter the diagnosis code that corresponds with the procedure code in element 24D. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in element 21.

Element 24F - Charges

Enter the total charge for each line item.

Element 24G - Days or Units

Enter the total number of services billed on each line item. A decimal must be indicated when a fraction of a whole unit is billed.

For most psychotherapy/substance abuse services, one unit equals one hour. Bill services in tenths of an hour, based on six-minute increments.

Table 3.3 illustrates the rules of rounding and gives the appropriate billing unit(s).

Table 3.3 *Billing in One-Tenth Hour Increments used in element 24G, "Days or Units."*

Billing in One-Tenth Hour Increments	
Time (in minutes)	*Unit(s) Billed*
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0
etc.	

Element 24I – EMG

Enter an "E" for ***each*** procedure performed as an emergency, regardless of the place of service (POS). If the procedure is not an emergency, leave this element blank.

Element 24K - Reserved for Local Use

When the billing provider (element 33) is a county-owned clinic (not a "biller only" provider), leave this element blank.

When the billing provider (element 33) is a tribal clinic or a "biller only" provider, indicate the performing provider's individual 8-digit provider number.

When applicable, enter the word "spenddown", and under it, enter the spenddown amount on the last detail line of element 24k directly above Element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 26 - Patient's Account No.

Optional - provider may enter up to 12 characters of the recipient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 28 - Total Charge

Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.) Do ***not*** enter Medicare-paid amounts in this field.

Element 30 - Balance Due

Enter the balance due as determined by subtracting the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.

This is the county or tribal agency responsible for the local matching funds.

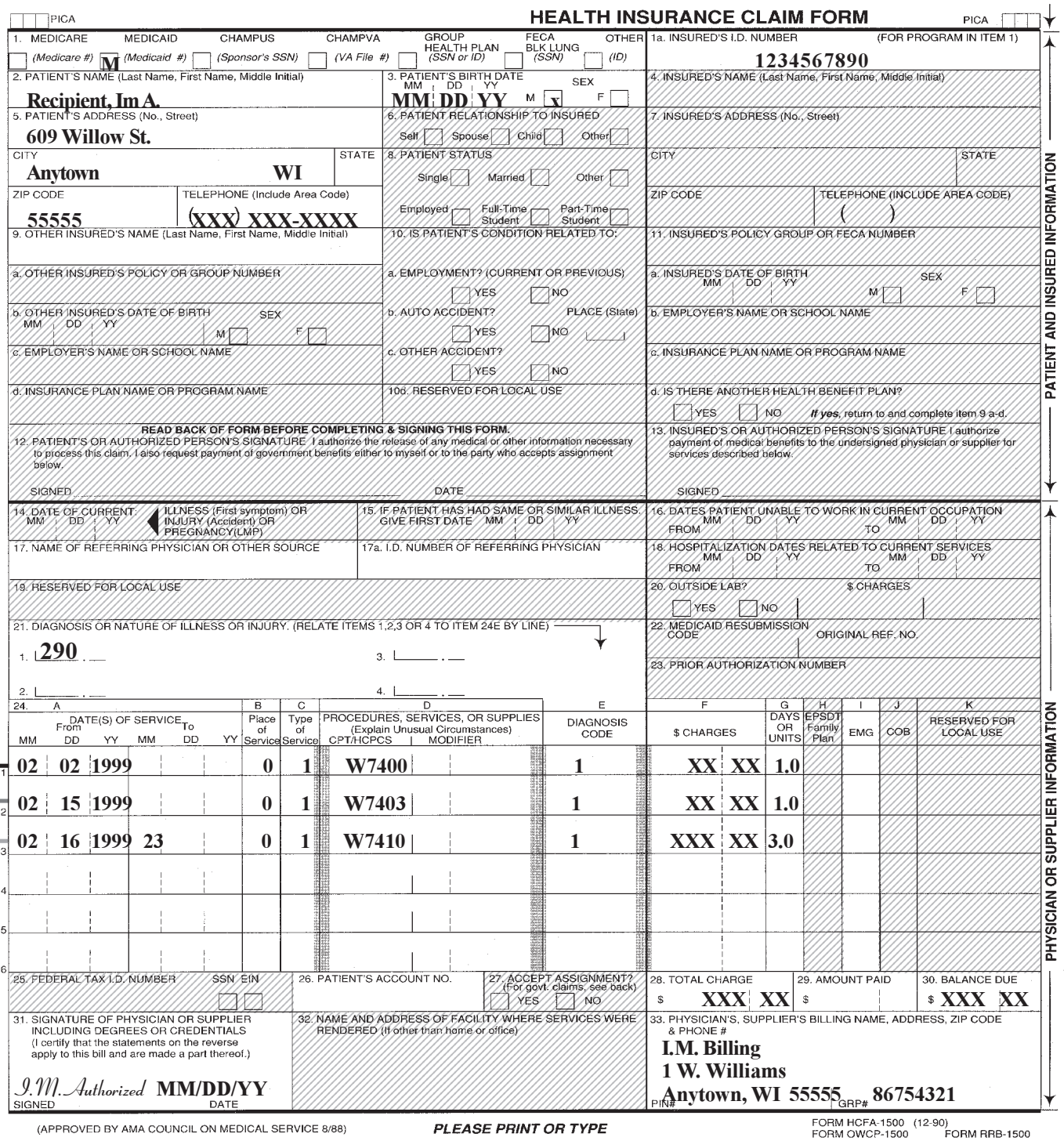
Elements Not Required

You are not required to enter information into the following elements of the HCFA 1500 when billing for mental health and substance abuse outpatient services in the home or community. These elements have been shaded on the claim form examples in Attachments 4 and 5. Entering information into these elements can result in claim denial: 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 24h, 24j, 24k (depending on circumstance), 25, 27, and 32.

Attachment 4
Mental Health and Substance Abuse Outpatient Services in Home or Community

Example of a Completed HCFA 1500 Claim for County-Owned Clinics

(Not a "Biller Only" Provider)



PICA — HEALTH INSURANCE CLAIM FORM — PICA

1. MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
(Medicare #) M (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID) ☐

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 290 . __ 3. ____ . __
2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 02 1999		0	1	W7400		1	XX XX	1.0				
2 02 15 1999		0	1	W7403		1	XX XX	1.0				
3 02 16 1999	23	0	1	W7410		1	XXX XX	3.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ — 26. PATIENT'S ACCOUNT NO. — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO — 28. TOTAL CHARGE $ XXX XX — 29. AMOUNT PAID $ — 30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized MM/DD/YY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 86754321

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Shaded elements of this form are not required. Entering information into the shaded elements can result in claim denial.

On date of service February 2, 1999, a psychiatrist provided one hour of a psychiatric diagnostic interview exam.

On date of service February 15, 1999, a psychiatrist provided one hour of individual psychotherapy.

On date of service February 16, 1999, a master's therapist provided 1-1/2 hours of group psychotherapy.

On date of service February 23, 1999, a master's therapist provided 1-1/2 hours of group psychotherapy.

Example of a Completed HCFA 1500 Claim for Tribal Clinics and "Biller Only" Providers

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID [P] (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M [x] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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1	02 02 1999	0	1	W7400		1	XX XX	1.0				24681012
2	02 15 1999	0	1	W7403		1	XX XX	1.0				87654321
3	02 16 1999 23	0	1	W7410		1	XXX XX	3.0				12345678
4												
5												
6												

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28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX XX

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